STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING _____ B. WING _____	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN46514

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 21, 22, 23, 24 and 25, 2011 Facility number: 155086 Provider number: 000034 Aim number: 100274880 Survey Team: Mavis Stob, RN TC Honey Kuhn, RN Carol Miller, RN (March 22, 23, 24 and 25, 2011) Census bed type: SNF/NF: 68 Total: 68 Census payor type: Medicare: 5 Medicaid: 53 Other: 10 Total: 68 Sample: 15 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-29-11 Cathy Emswiller RN	F0000	Division of Long Term Care 2 North Meridian Street Section 4B-07 Indianapolis, IN 46204 Office: 317-233-7321 Fax: 317-233-7322 April 6, 2011 Please accept this as our plan of correction for complaint survey dated March 21, 22, 23, 24, and 25, 2011event #JOR311. Woodland Manor is respectfully requesting a desk review. Sincerely, Kelly Duhaime Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0164 SS=D	Based on review of records, interview and observation the facility failed to maintain privacy in regard to closing the privacy and window curtains and applying a drape to cover the resident during treatment. This deficiency affected 1 of 4 residents observed during care and treatments, from a sample of 15. (Resident #32) Findings include: On 3/22/11 at 9:55 A.M., the clinical record of Resident #32 was reviewed and indicated an admission date of 12/27/10 and diagnoses which included but were not limited to, paraplegia, osteomyelitis and pressure areas to the buttocks and sacral area. The resident had been admitted for treatment to the pressure and attended the wound clinic daily for bariatric treatment to the pressure areas. The MDS (minimum data set) assessment, dated 1/7/11, indicated the resident had no cognitive impairment and was identified by the DNS (Director of nursing services) on 3/22/11 at 2:45 P.M., as interviewable. Documentation indicated an indwelling catheter was in place due to the pressure areas. On 3/23/11 at 1:00 P.M., the following was observed during treatment to the pressure ulcers for Resident #32:	F0164	F164 Our facility strives to provide the best care possible. In accordance with that policy, we have addressed the following issue. I Resident #32 shall receive care in a manner that promotes privacy. II Audited provision of resident care and found no other residents identified with this practice. III LPN #7 & 8 were educated regarding care in a manner that promotes privacy. All staff were educated regarding privacy of residents by 4/8/11. IV The Director of Nursing is responsible for the completion of quality assurance audit tools monitoring privacy weekly for 2 months, bi-weekly for 2 months, monthly for 2 months and as needed when deemed necessary by the QA committee. V	04/08/2011

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	Resident #32 was in the bed beside the window and the other resident in the room was lying on the top of the bed beside the door. LPN #8 was at the window, on the far side of the bed holding Resident #32 on his side facing the window. LPN #7 was removing the dressings from resident #32's buttocks. The privacy curtain was pulled halfway and resident #32 could be observed when the door was opened. The window was opposite a window in the dining room and the window curtain was not closed. There was no drape covering the exposed portion of the resident's body. During the treatment the resident was turned to the other side and placed on his back. At no time during this treatment were drapes used to cover the resident's body. At the end of the treatment, the resident was placed on his back and at this time a sheet was placed over the resident. Review of the dressing change policy, dated 3/08 and provided by the DNS, indicated "pull privacy curtain/close door" and " screen and drape resident for maximum privacy". On 3/24/11 at 2:00 P.M., the DNS was interviewed in regard to the lack of privacy during treatment and she indicated the resident had been a paraplegic for so many years that lack of privacy did not bother him, however the DNS agreed the curtains should have been pulled and the resident's exposed body should have been covered. 3.1-3(p)(2) 3.1-3(p)(4)		4/8/11	

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F0279 SS=D	Based on record review and interviews, the facility failed to ensure a Care Plan had measurable objectives and outcome in regard to when and how often a dialysis site should be monitored and who should be doing the monitoring. This deficiency affected 1 of 1 resident in the facility receiving dialysis. (Resident #53) Finding includes: The record of Resident #53 was reviewed on 03/22/11 at 8:30 a.m. Resident #53 was admitted to the facility on 02/06/11 with diagnoses including, but not limited to, aortic stenosis, ESRD (End Stage Renal Disease), weakness, difficult ambulation, PVD (Peripheral Vascular Disease: impaired circulation), diabetes, CHF (Congestive Heart Failure), chronic bronchitis, and stasis ulcers. Resident #53 received dialysis treatments on Monday, Wednesday, and Friday as well as outpatient visits to a local wound clinic for her stasis ulcers. During the initial tour, on 03/21/11 between 10:00 a.m. - 10:30 a.m. and accompanied by the DNS (Director Nursing Services), Resident #53 was observed in the hallway seated in a W/C (wheelchair). During interview at that	F0279	F279 Our facility strives to provide the best care possible. In accordance with that policy, we have addressed the following issue. I Resident #53 no longer resides at the facility. II Residents receiving hemodialysis will have set guidelines for checking bruit and thrill per shift. III An in-service will be given to nursing staff by the Director of Nurses (DON) on Hemodialysis and checking bruit and thrill per shift when a hemodialysis admission or new order for existing resident occurs. IV The DON or designee is responsible for the completion of an audit tool for 100% of residents receiving hemodialysis weekly for two months then bi-weekly for four months to assure proper documentation for checking bruit and thrill. Results are reported to the Quality Assurance Committee overseen	04/08/2011

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	time, the DNS indicated Resident #53 had incurred a fall resulting in injury while at dialysis on 02/28/11 resulting in admission to a local ACF (Acute Care Facility: hospital) and returned to the ECF (Extended Care Facility) on 03/10/11. Review of a "Renal Failure Plan of Care", initiated on 02/06/11, indicated: "Hemodialysis (removing unwanted chemical substances from the blood)" and included but not limited to the following: "Interventions: ... Monitor for complications following dialysis (i.e. hypotension [low B/P], febrile [increased temperature], bleeding/hemorrhaging, infection, septic shock)... Monitor vascular access: check bruit and thrill (sounds at access site), color, warmth, redness, edema, drainage, bleeding, dressing, position.... Obtain copy of labs and weights from dialysis center for review..." Review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) for 02/2011 and 03/2011 did not direct nursing staff to assess the resident's dialysis access site for the aforementioned areas.		by the Administrator. The DON is responsible for the completion of quality assurance (QA) audit tools for monitoring hemodialysis orders upon admission or new order for existing resident receiving hemodialysis occurs. The findings are reported to the quality assurance (QA) committee who meets monthly to determine if continued monitoring is still required. V 4/8/11	

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	Review of Nurses Notes indicated: 4 entries between 02/06/11 and 02/27/11 the resident's access site was checked for bruit and thrill. The Nurses Notes indicated the access site was assessed 1 time for bruit and thrill following the readmission on 03/10/11 and the resident being admitted to an ACF on 03/23/11. Interview with LPN #5 on 03/25/11 at 9:30 a.m. indicated the facility had no set guidelines for assessing dialysis residents and "just know to check for bruit and thrill every shift." Interview with LPN #6 on 03/25/11 at 11:05 a.m. indicated dialysis access sited were to be checked every shift and results recorded in the Nurses Notes. LPN #6 was unaware of a set guidelines for residents receiving dialysis. Interview with the DNS on 03/24/11 at 10:30 a.m. indicated the facility had no Policy & Procedure in regards care of dialysis residents. 3.1-35(b)(1)			

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F0282 SS=D	Based on record review and interviews, the facility failed to ensure the outpatient dialysis service agreement was followed in regard to care and treatment for 1 of 1 resident receiving outpatient dialysis treatment in a sample of 15 . (Resident #53) Finding includes: The record of Resident #53 was reviewed on 03/22/11 at 8:30 a.m. Resident #53 was admitted to the facility on 02/06/11 with diagnoses including, but not limited to, aortic stenosis, ESRD (End Stage Renal Disease), weakness, difficult ambulation, PVD (Peripheral Vascular Disease: impaired circulation), diabetes, CHF (Congestive Heart Failure), chronic bronchitis, and stasis ulcers. Resident #53 received dialysis treatments on Monday, Wednesday, and Friday as well as outpatient visits to a local wound clinic for her stasis ulcers. During the initial tour, on 03/21/11 between 10:00 a.m. - 10:30 a.m. and accompanied by the DNS (Director Nursing Services), Resident #53 was observed in the hallway seated in a W/C (wheelchair). During interview at this time the DNS indicated Resident #53 had	F0282	F282 Our facility strives to provide the best care possible. In accordance with that policy, we have addressed the following issue. I Resident #53 no longer resides at the facility. II Residents receiving hemodialysis will have documented collaboration of care meetings and communication between the Nursing Facility and Dialysis Unit. III An in-service will be given to nursing staff by the Director of Nurses (DON) on hemodialysis and communication documentation when a hemodialysis admission or new order for existing resident occurs. IV The DON or designee is responsible for the completion of an audit tool for 100% of residents receiving hemodialysis weekly for two months then bi-weekly for four months to assure proper documentation. Results are reported to the	04/08/2011

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	incurred a fall resulting in injury while at dialysis on 02/28/11 resulting in admission to a local ACF (Acute Care Facility: hospital) and returned to the ECF (Extended Care Facility) on 03/10/11. Interview with the DNS on 03/24/11 at 10:30 a.m. indicated the facility had no Policy & Procedure in regards care of dialysis residents. The DNS was queried in regards to a Dialysis Book or other tool to facilitate communication between the facility and the dialysis unit. On 03/24/11 at 1:10 p.m., the DNS provided a binder which contained a copy of the "Hemodialysis Flowsheet" from the dialysis unit from the 03/21/11 visit. Review of a Outpatient Dialysis Services Agreement, dated 01/11/11, and provided by the Administrator on 03/25/11 at 1:00 p.m., indicated: "A. Obligations of Nursing Facility and/or Owner... 2. Interchange of Information: The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD Residents, including a Registered Nurse as a contact person at the Nursing Facility, whose responsibilities include oversight		Quality Assurance Committee overseen by the Administrator. The DON is responsible for the completion of quality assurance (QA) audit tools for monitoring hemodialysis communication upon admission or new order for existing resident receiving hemodialysis occurs. The findings are reported to the quality assurance (QA) committee who meets monthly to determine if continued monitoring is still required. V 4/8/11	

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	of Services to the ESRD Residents.... B. Obligation of the ESRD Dialysis Unit and/or Company 1. To provide to the Nursing Facility information on all aspects of the management of the ESRD Resident's care related to the provision of Services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis access site.... D. Mutual Obligations 1. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Nursing Facility and the applicable ESRD Dialysis Unit. Review of a "Renal Failure Plan of Care", initiated on 02/06/11, indicated: "Hemodialysis (removing unwanted chemical substances from the blood)" and included but not limited to the following: "Interventions: ... Monitor for complications following dialysis (i.e. hypotension [low B/P], febrile [increased temperature], bleeding/hemorrhaging, infection, septic			

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	shock)... Monitor vascular access: check bruit and thrill (sounds at access site), color, warmth, redness, edema, drainage, bleeding, dressing, position.... Obtain copy of labs and weights from dialysis center for review..." Review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) for 02/2011 and 03/2011 did not direct nursing staff to assess the resident's dialysis access site for the aforementioned areas. Review of Nurses Notes indicated: 4 entries between 02/06/11 and 02/27/11 the resident's access site was checked for bruit and thrill. The Nurses Notes indicated the access site was assessed 1 time for bruit and thrill following the readmission on 03/10/11 and the resident being admitted to an ACF on 03/23/11. Interview with LPN #5 on 03/25/11 at 9:30 a.m. indicated the facility had no set guidelines for assessing dialysis residents and "just know to check for bruit and thrill every shift." Interview with LPN #6 on 03/25/11 at 11:05 a.m. indicated dialysis access sited			

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	were to be checked every shift and results recorded in the Nurses Notes. LPN #6 was unaware of a set guidelines for residents receiving dialysis. 3.1-35(g)(1)			

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F0315 SS=D	Based on Review of records and interview, the facility failed to ensure a comprehensive assessment was made in regard to catheter insertion for 1 of 3 residents reviewed for catheter insertion in a sample of 15. (Resident #46) Findings include: The clinical record of Resident #46 was reviewed on 3/22/11 at 11:00 A.M., and indicated an admission date of 6/3/10, and diagnoses which included but were not limited to urinary tract infection and chronic renal failure. An admission assessment, dated 6/4/10, indicated the resident was incontinent of urine and bowel. Hospital discharge orders, dated 6/3/10, indicated the catheter should be removed on admission to the facility and re- inserted if the resident was unable to void. Documentation in the nurses notes, dated 6/3/10 at 7:30 P.M., indicated the catheter was removed. The next note was dated 6/4/10 at 7:00 a.m., and indicated "attempted x 2 to reinsert 16 FR (size of the catheter)foley unsuccessful will attempt after breakfast" and 9:30 A.M., "14 FR foley inserted c (with) 100 cc output". There was no assessment in	F0315	F315 Our facility strives to provide the best care possible. In accordance with that policy, we have addressed the following issue. I Resident #46 was assessed for catheter appropriateness. Physician was notified and order to discontinue catheter was obtained. Resident was placed on bladder monitoring with results reported to physician. II Residents with catheters were assessed for appropriateness with focus on current physical condition and previous urinary history. III Licensed nurses were educated on 4/8/11 regarding catheter assessments and bladder monitoring tool implemented. (See attachment F315A) IV The Director of Nursing is responsible for the completion of an audit for catheter appropriateness for 100% of	04/08/2011

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	regard to attempts to void or if there was discomfort or abdominal distension. The foley catheter assessment form, dated 6/10/10, indicated "urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible". In addition, the form indicated the resident had a neurogenic bladder due to a catheter being removed and the resident unable to void. Documentation in the nurses notes, dated 8/17/10, indicated the resident requested to have the catheter removed and on 8/17/10 at 11:10 A.M., the catheter was removed. The next nurses notes, dated 8/17/10 at 3:30 P.M., indicated "remains unable to void, denies bladder distension or discomfort" and at 9:00 P.M., "incont (incontinent) of stool but no urine. Cleaned, repositioned in bed and foley #14 anchored c 20 cc of yellow urine noted". There was no documentation in regard to abdominal distension or discomfort. On 3/23/11 at 9:30 A.M., the DNS was interviewed in regard to the bladder/catheter assessment for Resident #46 and whether there was the possibility that the resident was incontinent of urine when she was incontinent of stool. The DNS was also asked if there was any		residents with catheters for three months, and 50% for three months. Results are reported to Quality Assurance (QA) Committee overseen by the Administrator. V 4/8/11 **72 HOUR BOWEL AND BLADDER ELIMINATION ASSESSMENT TOOL** Time When asked the resident states they are D = Dry W = Wet When toileted/ checked the resident was D = dry W = Wet When toileted, the resident voided The voided amount was L = Large M = Medium S = Small D = Dry Bowel Movement L = Large M = Medium S = Small N = None Intake CCs Initials Date	

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	other information in regard to the diagnosis of neurogenic bladder. The DNS indicated she was following the physician's orders to re-insert the catheter if the resident was unable to void. A quarterly assessment, dated 2/16/11, indicated the resident had no cognitive impairment and was identified by the DNS as interviewable. On 3/24/11 at 1:20 P.M., Resident #46 was interviewed and indicated she was incontinent of urine prior to coming to the facility and when queried in regard to the catheter the resident indicated if she did not have the catheter she would be wet all the time. 3.1-41(a)(1) 3.1-31(a)(2)		MN D W D W Y N L M S D L M S N 02 D W D W Y N L M S D L M S N 04 D W D W Y N	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING _____ B. WING _____	03/25/2011

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F0323 SS=D	Based on observation, record review and interviews, the facility failed to ensure the safety for 1 resident who incurred 8 falls over 9 days. This deficiency effected 1 of 6 residents in a sample of 15 reviewed for falls. (Resident #53) Finding includes: During the initial tour, on 03/21/11 between 10:00 a.m. - 10:30 a.m. and accompanied by the DNS (Director Nursing Services), Resident #53 was observed in the hallway seated in a W/C (wheelchair). Resident #53 was noted to have discoloration around both eyes. During interview at that time, the DNS indicated Resident #53 had incurred a fall resulting in injury while at dialysis on 02/28/11. Resident #53 sustained a closed head injury requiring admission to a local ACF (Acute Care Facility: hospital) and returned to the ECF (Extended Care Facility) on 03/10/11. The DNS indicated Resident #53 had incurred several falls since readmission. The DNS indicated Resident #53 was interviewable when admitted but recently was more confused. On 03/22/11, at 8:15 a.m., the Administrator indicated the facility had changed the resident from a standard W/C (wheelchair) to a reclining wheelchair to	F0323	F323 Our facility strives to provide the best care possible. In accordance with that policy we have addressed the following issue. I Resident #53 no longer resides at this facility. II Assessment forms updated and implemented for a more thorough investigation, identifying the root cause and preventing other falls from potentially occurring. III Nursing staff were educated by 4/8/11 regarding the importance of assessments and updated internal forms. Post fall investigation form updated to include Fall Report, Fall Investigation/Follow-Up, and Risk Management Risk Factor Identification (See attachments: F323A, F323B, F323C) IV Director of nursing or designee is responsible the completion of the quality assurance (QA) audit tool which monitors Falls daily for the	04/08/2011

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	prevent the resident from falling. Resident #53 was observed, on 03/22/11 at 1:00 p.m., seated in a standard W/C, being wheeled in the hallway by a family member. The family member was heard to say to a staff member , "be sure to put the alarm back on this wheelchair." On 03/23/11 at 10:45 a.m., LPN #6 indicated Resident #23 had been admitted to a local ACF from the Wound Clinic for her stasis ulcer. The record of Resident #53 was reviewed on 03/22/11 at 8:30 a.m. Resident #53 was admitted to the facility on 02/06/11 with diagnoses including, but not limited to, aortic stenosis, ESRD (End Stage Renal Disease), weakness, difficult ambulation, PVD (Peripheral Vascular Disease: impaired circulation), diabetes, CHF (Congestive Heart Failure), chronic bronchitis, and stasis ulcers. Resident #53 received dialysis treatments on Monday, Wednesday, and Friday as well as outpatient visits to a local wound clinic for her stasis ulcers. Review of Nurses Notes indicated the resident incurred a fall on 02/25/11 at 1:30 a.m. while attempting to transfer unassisted from her bed to her W/C.		next 3 months (3) three times a week for the next 3 months and as needed when deemed necessary by the QA Committee. V 4/8/11 **Fall Investigation/Follow-Up** Resident Name _____ _____ _____ _____ Room # _____ ____ Date of Fall _____ _____ _____ Time of Fall _____ _____ Current safety measures in place (refer to care plan). _____ _____ _____ ___ _____ _____ _____ _____ _____ _____ _____ _____ _____	

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	Further review of Nurses Notes indicated: "02/28/11 6:30 p.m. This nurse received a phone call from nurse from (ACF name). She stated that the resident's W/C tipped over & (and) the resident sustained a goose egg on the (R) (right) side of head. The resident is a direct admit to the (ACF) under (Physician's name) in ICU (Intensive Care Unit)...." Review of a "Consultation" report, dated 03/02/11 from the ACF, indicated: "HISTORY OF ILLNESS: ...a CT scan of the brain that did show a 9 mm (millimeter) hemorrhage in the medial left frontal lobe...." "IMPRESSION: 1. ...a traumatic brain injury from a fall. This is associated with a left frontal lobe hemorrhage...." "03/10/11 Arrived from (ACF) per (EMS name) ambulance & readmitted to rm (number)...." Following readmission, the resident incurred falls on the following dates/times: 03/14/11 11:20 p.m. 03/15/11 09:35 p.m. 03/16/11 18:02 (6:02 p.m.) 03/17/11 04:45 a.m.		_____ _____ _____ _____ _____ _____ _____ _____ _____ Did current safety measure contribute to the fall? YES NO If YES, explain: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ **Medications Used Prior to fall:** Cardiovascular Diuretics (Within 8 hours before fall) Psychoactive If Yes ortho BP _____lying BP _____sitting BP _____standing BP _____ New medications ordered in the past week? _____ _____ _____ _____ Any abnormal responses to new meds?	

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	03/18/11 05:15 a.m. 03/22/11 04:20 a.m. 03/22/11 04:02 p.m. 03/22/11 04:22 p.m. Documentation indicated Resident #53 was placed on 15 minute checks on 03/18/11 at 6:30 a.m. through 03/22/11 at 11:45 a.m., which were completed except when the resident was out of the facility at dialysis. Nurses notes indicated: "03/22/11 4:15 a.m. Res. up in W/C most of noc (night). Attempting to transfer self Q (every) 15 min. Checks cont. (continued). .." "03/22/11 4:20 a.m. Nurse seen (sic) .res. lean forward in W/C d/t (due/to) sitting by desk. Nurse unable to stop res. from falling forward out of W/C...Res. states she hit (L) (left side of head. 0 (no) hematoma or swelling noted...." "03/22/11 8:15 a.m. Writer observed moderate amount of emesis, clear colored fluid noted..." "03/22/11 1:00 p.m. Resident A&O (alert and oriented) X 1. Increase confusion noted...physician notified..." "03/22/11 4:02 p.m. Resident found lying on the floor by her bed and wheelchair. Alert, awake, denies hitting head...bed alarm and floor mat in placed (sic) c		_____ _____ _____ _____ _____ _____ _____ _____ _____ **Diagnosis Relevant to Falls;** Acute Conditions: UTI URI Sig Wt. Loss Other Chronic: CVA Arthritis Parkinson's Seizures Vision Problems Dementia TIA's COPD Psych Other: _____ _____ _____ _____ _____ **Abnormal Labs (past 6 weeks)** BUN BL Sugars Lytes CBC C&S Other Usual status of resident (related to falls): Cognitive: Alert Oriented Confused Varies Judgment: Not Aware of Safety Good Judgment Varies Communication: Makes Needs Known Unable to Make Needs Known	

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	(with) call light @ ((at) reach..." "03/22/11 4:20 p.m. (Physician's name) called back. Reported that res. had fallen again...Order for psyche (psychiatric) eval (evaluation) received." "03/22/11 4:22 p.m. Res. bed alarm going off. Found resident on floor trying to get to her wheel chair...." Review of a Care Plan, titled "Potential for Falls....", and initiated upon admission on 02/06/11, indicated, "Intervention" following the initial fall on 02/25/11, "Encourage (Resident's first name) to use call light for assistance." The care plan was not updated following readmission to the facility, on 03/10/11 for a fall with a closed head injury, until after the resident fell on 03/14/11. Interventions indicated: "03/16/11: Remind res to use call light for assist to ambulate to bathroom.: "03/17/11 Apply bed & chair alarms." "03/18/11 Apply safety mat." The Administrator provided copies of 6 "Post Fall Investigation Forms" and 5 internal "Incident-Accident Report" forms on 03/23/11 at 8:45 a.m. The Post Fall Investigation forms were not completed and did not indicate interventions previously put in place were being followed.		Vision; Functional Non Functional Hearing: Functional Non Functional Gait: Unable to Assess Normal Unsteady Balance Problems: Yes No Amputation: Yes No Behavior/Mood Problems: Yes No Explain: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ were changes noted in usual status prior to fall? Yes No Describe: _____ _____ _____ In reviewing the above data, what contributed to the fall, note any commonalities with previous falls and explain prevention interventions: _____ _____ _____ _____ _____ _____ _____ _____ _____	

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	Review of the Incident/Accident Reports indicated in the "Additional comments and/or steps taken to prevent recurrence" for 2 of the 5 reports: "03/14/11 11:20 p.m.: Encouraged res. to use call light to ask for help." "03/22/11 04:20 a.m.: Pt (patient) will be monitored frequently, call light in reach, W/C alarm, bed alarm, labs reviewed, 15 min (minute) monitoring." Interview with the DNS, on 03/24/11 at 1:00 p.m. indicated the facility had thoroughly investigated the falls and put interventions in place. The DNS indicated the resident remained inpatient status in an ACF. 3.1-45(a)(2)		Care Plan Reviewed and up to date Yes No New interventions/safety measures that were put in place:_____	

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			__ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ ___ Signature: _____ _____ _____ Date: _____ _____ Initial: _____Administrator _____ Director of Nursing _____ Unit Manger Attachment: F323A Attachment: F323B **Fall Report**	

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			Date of fall _____ _____ Time _____ _____ AM/PM _____ _____ Resident Name _____ _____ _____ Room # _____ MR # _____ M.D. notified? _____ _____ POA/Family notified? _____ _____ _____ Has resident fallen in the past 6 months? Yes No Detailed description of the fall and what we think the resident was trying to do at the time of the fall _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	

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			_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ **Current Safety Devices in Use:** Tab Alarm Pressure Alarm Broda Chair Transfer Loop Lap Buddy Other Describe: _____ _____ Alarm Sounding at Time Yes No (If no, explain) N/A _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ **Environment at the time of the fall:** Yes No Yes No	

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			Yes No Lighting O.K. Call Light in Reach Different Environment to Resident Floor Dry Room Changes in the Past Month (if yes, explain): _____ _____ Recent Changes in Environment _____ _____ **Check all appropriate boxes:** _____ _____ ___ **Task** **Location** **Assistive device** **Current Transfer Ability** Transferring Resident Room	

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F0425 SS=D	Based on observation, record review and interviews the facility failed to assure medications in the container where as ordered by the Physician in regard to different dosages of a medication in the same medication container. This deficiency affected 1 of 15 residents whose medications were reviewed in a sample of 15. (Resident #35) Findings include: Review of the record of Resident # 35 on 3/24/11 at 3:20 p.m., indicated diagnoses which included, but were not limited to, depression. On 3/23/11 at 8:30 a.m., during a medication administration pass, LPN #6 was observed to compare Resident #35's medication container of Zoloft (antidepressant) against the Medication Administration Record (MAR). The MAR indicated Zoloft 25 milligrams (mg) take 1 tablet once a day and the bottle container indicated administer Zoloft 100 mg give one half (1/2) tablet which equals 50 milligrams once a day. LPN #6 did not give the Zoloft and indicated she held the medication until she clarified with the Physician the correct dosage. The medication bottle was observed to contain both 1/2 and 1/4 tablets. Physician's order dated 7/8/08, indicated to discontinue Zoloft 100 mgs and administer Zoloft 50 mgs once a day. On 1/12/11, the Physician	F0425	F425 Our facility strives to provide the best care possible. In accordance with that policy, we have addressed the following issue. I Resident # 35 was not harmed II Residents receiving medication from a supplier other than facility providing pharmacy will receive all medications with the proper dosage timely. Medication not received timely will be ordered from the facility providing pharmacy. III An in-service will be given to nursing staff by the Director of Nurses (DON)regarding the importance of proper medication dosages supplied by other pharmacies, and the importance of ordering from facility pharmacy provider if outside pharmacy provider has not delivered proper medication order timely. IV The DON or designee is responsible for the completion of random medication audits for 100% of residents receiving medications from a supplier other	04/08/2011

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	order for the Zoloft indicated to decease the Zoloft to 25 mgs one tablet once a day On 3/23/11 at 10:45 a.m., the Administrator was queried in regard to the Resident's medication for Zoloft and indicated there were 1/2 and 1/4 tablets in the same medication container and there was a change of medication label on the container bottle of Zoloft. The Administer indicated the Resident's Zoloft had now been destroyed and the facility pharmacy had been contacted and the Zoloft 25 mg. was ordered and would be at the facility in the morning. On 3/23/11 at 11:00 a.m., LPN #6 was queried in regard to the Zoloft medication dosage and indicated she had contacted the Physician in regard to the Zoloft 25 mg once a day dose. The physician indicated to continue the Zoloft 25 mg dose and to monitor the resident for behaviors. LPN #6 indicated the Zoloft medication for 25 milligrams was received from the pharmacy and administrated to Resident #35. On 3/23/11 at 1:15 p.m., the Director Nursing Services (DNS) was queried in regard to the resident's Zoloft medication and indicated the Zoloft medication was provided by mail order to the family from the Veterans Administration (VA). The DNS indicated when the Zoloft dosage changed from 50 mgs to 25 mgs. the VA was contacted and indicated the facility should use a pill cutter to cut the 50 mgs tablets in half (25 mg) On 3/23/11 at 1:30 p.m., LPN #5 was queried in regard to the Zoloft LPN #5 and indicated when the order changed from 100 mgs to the 50 mgs the tablets were scored so he cut the Zoloft tablet in half and when the order changed from Zoloft 50 mgs to 25 mgs he cut the tablet in fourths		than facility pharmacy provider for six months. The findings are reported to the quality assurance (QA) committee who meets monthly to determine if continued monitoring is still required. V 4/8/11	

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	following instructions from the VA pharmacy . On 3/23/11 at 2:15 p.m., LPN #6 was queried in regard to the Zoloft dosage and LPN #6 indicated she had not worked on the 300 hall for over a month. On 3/24/11 at 8:15 a.m., the DNS was queried in regard to Resident #35's Zoloft and indicated she had interviewed the 3 nurses who worked on the 300 hall and the 3 nurses indicated they had administered Zoloft one fourth of a tablet. 3.1-25(k)(4)			

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F0441 SS=D	Based on review of records, interview and observation the facility failed to ensure the policy for a dressing change was followed in regard to handwashing. In addition the facility failed to ensure the wounds would not be contaminated by loose hair. This deficiency affected 1 of 3 residents, and 1 of 3 nurses observed during dressing changes or care, in a sample of 15. Resident #32 and LPN #7. Findings include: On 3/23/11 at 1:00 P.M., observations were made during a dressing change for Resident #32. LPN #7 performed the dressing change assisted by LPN #8. Both wore gloves and followed the policy prior to and during the treatment. When the treatment was finished LPN #7 placed all used dressings and equipment in a plastic bag, removed her gloves and left the room without washing her hands. Review of the dressing change policy, dated 3/8, and provided by the DNS indicated : "Procedure 16. remove gloves and discard with all unused supplies in plastic bag 17. Wash hands with soap and water or sanitizer". LPN #7, who was performing the treatment had long hair and when she bent	F0441	F441 Our facility strives to provide the best care possible. In accordance with that policy We have addressed the following issue. I Resident #32 was not harmed II LPN #7 was educated on proper hand washing following a dressing change, and importance of prevention of hair falling forward preventing the potential for contamination of the wounds. III All staff were educated and evaluated for proper hand washing and prevention of hair falling forward preventing the potential for contamination by 4/8/11. IV Director of Nursing (DON) will evaluate staff weekly at random for proper hand washing weekly for two months, bi-weekly for two months, monthly for six months and then ongoing. Results to the Quality Assurance Committee.	04/08/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	over the areas being treated her hair fell forward with the potential for contaminating the wound areas. On 3/24/11 at 2:00 P.M., the DNS was interviewed in regard to the concerns and indicated LPN #7 usually tied her hair up so it could not fall forward. 3.1-18(a) 3.1-18(l)		V 4/8/11	